STATE POLICY RECOMMENDATIONS FOR PHARMACIST ADMINISTRATION OF MEDICATIONS

A REPORT FROM THE STAKEHOLDER GROUP
CONVENED BY THE NATIONAL ALLIANCE OF STATE PHARMACY ASSOCIATIONS
AND THE COLLEGE OF PSYCHIATRIC AND NEUROLOGIC PHARMACISTS

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IDENTIFYING AND DEVELOPING STATE BEST PRACTICES FOR PHARMACIST ADMINISTRATION OF MEDICATIONS

PROJECT OVERVIEW

Over the last several decades, pharmacists have been taking on greater patient care roles. One such role is in the administration of vaccines. In the 1990s only a handful of pharmacists across the country were trained to administer vaccines. Today nearly all community pharmacists have been trained and have incorporated this service into their practice. The opportunity to administer important vaccines in community pharmacies allows access to patients who may otherwise not have been able to adhere to public health recommendations.

Although pharmacist administration of vaccines is allowed in all 50 states and in the District of Columbia, many states in the US still restrict the scope of pharmacist administration of vaccines and other injectable medications. Pharmacists' overall success with vaccines has the potential to be translated to the administration of other medications—especially long-acting injectable (LAI) antipsychotic medications. LAIs can be life changing for patients in need of this care yet have trouble adhering to complex administration schedules for the pill forms of the medications. Unfortunately, access to providers who are able to administer LAIs is limited, due to various factors.

There is a public health need in the US for increased access to mental health services—including LAIs. Due to their accessibility, education and training, pharmacists have the potential to help provide an additional and needed access point. However, there are few decision-making resources currently available regarding pharmacist administration of medications beyond vaccines for health care plans and other payers and policy makers. Recognizing these needs, the National Alliance of State Pharmacy Associations (NASPA) partnered with the College of Psychiatric and Neurologic Pharmacists (CPNP) to convene a group of stakeholders to examine the available information and develop recommendations for state policy. Although the recommendations are intended to be encompassing of all non-vaccine medications, the issue was examined through the lens of LAIs. It was identified that this medication class may have the most urgent public health need for increased access.

BACKGROUND

THE NEED FOR INCREASED ACCESS

There is a need for increased access to medication administration services for many types of medications, such as those used to treat osteoporosis, specialty medications, and supplements that must be provided by a health care professional. Additionally, there are a variety of self-administered injectable medications that patients or caregivers are expected to administer at home. In some cases, due to dexterity deficiencies, fear of needles, or other challenges, there is a need for a highly accessible health care provider to provide medication administration services for the patient. Without access to an alternative, patients who are unable to self-administer may be less adherent or not take their medications at all.

In the mental health sector, the problem with non-adherence is prevalent. About half of patients diagnosed with schizophrenia do not take their medications as prescribed.[1-6] This high rate of non-adherence can be linked to clinical relapses and hospitalizations which can cause significant distress for the patient and high costs for the health care system.[7,8] Specifically during a first episode, readmission rates are five times higher in those patients who are non-adherent compared to an adherent population.[9-11]

Although many patients who have tried LAIs prefer them over oral products, uptake in the United States has been limited since they were first introduced on the market in 1967.[12-14] Low use in the US may be due to how the injection is being offered—with a focus on the procedure rather than the potential benefits, fear of needles, and logistical complications for administering the medications in the clinic where they are prescribed.[15] Some examples of the logistical challenges include:

- scheduling challenges and crowded waiting rooms due to increased office visits,
- limited personnel in the clinic to administer and schedule injections,
- the cost of maintaining an inventory of the medications in the clinic,
- reimbursement policies that require they be dispensed by a pharmacy, and
- patient transportation barriers.

PHARMACISTS' ROLE

Pharmacists are well positioned to address some of the challenges described above. In addition to pharmacists' medication expertise, offering medication administration can alleviate many of the geographical barriers that challenge clinicians and patients. This is due to the high accessibility of community pharmacies, which are often much closer to the patient's home and offer more extensive hours of operation than a clinic setting. Pharmacies are designed for on-demand service delivery—as has been implemented for vaccine administration, and they are equipped to handle and maintain a large medication inventory. Additionally, by having LAIs administered in a community pharmacy setting, some of the stigma associated with a patient needing to go into a specific-type of clinic is resolved. In the community pharmacy setting, patients are receiving their important medications in the same way that others receive their flu shot, which includes policies and procedures for communicating care delivery back to the patient's health care provider and other care coordination services.[16,17]

EXISTING POLICY AND STAKEHOLDER DISCUSSION AND RECOMMENDATIONS

When the stakeholder group met, they first reviewed level-setting information regarding the need for increased access and the role that pharmacists can play. They then examined research on the current status of state policies governing pharmacist administration of medications—this research was summarized and included in the sections below to provide context to the stakeholder discussion and recommendations. Participants were asked to consider the following key questions during their discussion:

- Is this policy in the best interest of the patient?
- Does this policy align with pharmacist education and training (or that which could be feasibly obtained)?

The following reflects the discussion and recommendations from the stakeholder group convened by NASPA and CPNP. It does not necessarily represent the position of the organizations for which the participants represent.

GENERAL AUTHORITY FOR PHARMACIST ADMINISTRATION OF MEDICATIONS

Existing Policy

All states allow pharmacists to administer vaccines, with some variability in the patient age, types of vaccines and/or process. There are 40 states that allow pharmacists to administer other prescribed medications with varying levels of restrictions. Of these, 36 allow for the administration of antipsychotic medications pursuant to a prescription. However, in eight of those states, a collaborative practice agreement (CPA) is required. A CPA is a formal practice relationship between pharmacists and other health care practitioners. The agreement allows for certain patient care functions, in this case the administration of medications, to be delegated to the pharmacist by the collaborating prescriber.

Stakeholder Discussion and Recommendation

> **It is recommended that pharmacists should be authorized to administer any medication, pursuant to a valid prescription and proper training.**

Despite variability in state law, the group recognized the current availability of pharmacist-provided medication administration services and the competencies of pharmacists to broaden access for patients. It was discussed that some medications require surgical technique to administer, such as contraceptive implants. The group considered listing the acceptable routes for pharmacist administration of medication. Instead, the recommendation was that policy should be left more general to prevent hindering future innovations. Additionally, pharmacists' scope is restrained by market factors such as liability, facility privileging, and because prescriptions for very specialized medications would not be sent to a pharmacy and instead would be administered in an office or clinic setting.

PHARMACIST TRAINING

INITIAL TRAINING

Existing Policy

Currently 27 of the 40 states that authorize pharmacists to administer medications do not specify what specific training is required. Instead, these states leave it to the professional responsibility of the pharmacist to act in the best interest of the patient and administer only those medications for which

appropriate training has been obtained. The remaining 13 states have varying degrees of specificity regarding initial training requirements.

Stakeholder Discussion and Recommendation

> **It is recommended that medication administration training be obtained from an ACPE accredited program (which may include educational experiences obtained through pharmacy school curricula) appropriate for the medications being administered and their respective patient populations. Administration techniques must be covered but not necessarily in the same program.**

Though not recommended to be detailed in the law, the committee discussed the importance of the following elements as components, in addition to administrative technique, in quality medication administration training programs: dosing and storage requirements, patient engagement regarding the underlying condition and symptoms being treated, stigma, patient support networks, side effect management, patient education, relevant comorbid conditions, and appropriate policies and procedures such as documentation and communication (including referral) with the prescriber on the status of the patient and their medication administration.

CONTINUING EDUCATION

Existing Policy

In current law, there are seven states that have medication administration-specific continuing education requirements for pharmacists seeking to maintain their eligibility to administer medications (ranging from one to three required hours per year). It should be noted that this is in addition to maintaining CPR or BCLS certification in most instances.

Stakeholder Recommendation

> **It is recommended that state laws and regulations should not identify a specific number of continuing education hours but there should be an expectation that the pharmacist maintain continued competency regarding the populations they serve, medications they administer, and current guidelines.**

It was discussed that pharmacists have the professional responsibility to maintain their competency but that setting a specific number of continuing education hours was not necessary.

POLICIES AND PROCEDURES

Existing Policy

There are limited examples of states that have specific requirements regarding the policies and procedures associated with pharmacist administration of medications. For example, there are four states with requirements for notifying the prescriber once the pharmacist has administered the medication and seven with policies regarding documentation procedures. The stakeholder group considered each of these, and others, individually but ultimately developed the following policy recommendation.

Stakeholder Discussion and Recommendation

> **It is recommended that the pharmacy practice must develop and maintain written policies and procedures covering all aspects of the administration of medications that ensure patient safety, appropriate coordination of care, and address documentation.**

It was discussed that appropriate policies and procedures are essential for high quality care delivery involving medication administration and should include documentation, when prescribers are to be notified that a medication was administered or when a patient misses an appointment, situations where patients need to be referred back to the prescriber, proper storage and handling of medications, etc.

It was not recommended that states develop laws or regulations with detailed requirements on policies and procedures in order to allow flexibility to accommodate different medication classes and practice variations. The policies and procedures developed by the practice should be in alignment with the standards of practice for other health professionals administering medications. Best practices for policies and procedures should be included in education programs about medication administration.

Of note, the importance of care coordination and the need for its inclusion in the policies and procedures was discussed. Care coordination is important in the treatment and management of all conditions and medications and is of particular importance for the administration of LAIs and the associated mental health conditions. For this group of high risk patients who often have a hard time with consistent treatment, clear pathways of communication between the prescriber and pharmacist are important.

ORDER TO ADMINISTER

Existing Policy

Currently, 27 states allow pharmacists to administer medications pursuant to a valid prescription. The other 13 states that allow pharmacist administration beyond vaccines, require one of the following, in addition to a valid prescription, from the prescriber:

- Collaborative practice agreement
- Medical order
- Standing order or protocol

Stakeholder Discussion

A recommendation was not developed regarding the need for an order to administer. The importance of care coordination, especially as part of the administration of LAIs was discussed. As mentioned in the above section on policies and procedures, practices should develop methods of ensuring care coordination and communication, including but not limited to utilization of collaborative practice agreements, medical orders, standing orders, or protocols.

BOARD NOTIFICATION

Existing Policy

There are currently seven states that require that pharmacists who are trained to administer medications receive some type of certification from the board of pharmacy (such as an “authority to administer”) or to notify the board of pharmacy of their training. In some states this includes an application and a fee.

Stakeholder Discussion and Recommendations

> **It is recommended that pharmacists should not be required to notify the board of pharmacy that they have been trained or to obtain a certification beyond licensure in order to administer medications.**

Participants discussed that these requirements create an administrative burden that does not subsequently improve patient care.

CONCLUSION

Overall, the stakeholders felt that pharmacists can play a vital role in increasing access to medication administration services. States that currently do not allow pharmacists to administer medications or that have inhibitive restrictions should consider incorporating the above policy recommendations into their state laws and regulations.

REFERENCES

1. Hirsch SR, Barnes TRE. The clinical treatment of schizophrenia with antipsychotic medications. In S.R. Hirsch & D.R. Weinberger (Eds) Schizophrenia. Oxford: Blackwell. 1995.
2. Dolder CR, Lacro JP, Dunn LB, Jeste DV. Antipsychotic medication adherence: Is there a difference between typical and atypical agents? American Journal of Psychiatry 2002;159:103-8.
3. Olfson M, Mechanic D, Hansell S, Boyer CA, Walkup J, Weiden P. Predicting medication noncompliance after hospital discharge among patients with schizophrenia. Psychiatric Services 2000;51:216-222.
4. Velligan DI, Lam FYW, Ereschefsky L, Miller AL. Psychopharmacology: Perspectives on medication adherence and atypical antipsychotic medications. Psychiatric Services 2003;54:665-667.
5. Gilmer TP, Dolder CR, Lacro JP, Folsom DP, Lindamer L, Garcia P, et al. Adherence to treatment with antipsychotic medication and health care costs among Medicaid beneficiaries with schizophrenia. American Journal of Psychiatry 2004;161:692-699.
6. Velligan DI, Diamon PM, Lopez J, Castillo DA, Maples N, Lam F, et al. Cognitive adaptation training improves adherence to medication and functional outcome in schizophrenia. Schizophrenia Bulletin 2007;33:608.
7. Knapp M, King D, Pugner K, et al. Non-adherence to antipsychotic medication regimens: associations with resource use and costs. Br J Psychiatry 2004;184:509-16.
8. Damen J, Thuresson PU, Heeg B, Lothgren M. A pharmacoeconomic analysis of compliance gains on antipsychotic medications. Appl Health Econ Health Policy 2008;6:189-97.
9. Barkhof E, Meijer CJ de Sonneville LM, et al. Interventions to improve adherence to antipsychotic medication in patients with schizophrenia-a review of the past decade. Eur Psychiatry 2012;27:9-18.
10. Subotnik KL, Nuechterlein KH, Ventura J, et al. Risperidone nonadherence and return of positive symptoms in the early course of schizophrenia. Am J Pyschiatry 2011;168:286-292.
11. Novick D, Haro MJ, Suarez D, et al. Predictors and clinical consequences of non-adherence and return of positive symptoms in the early course of schizophrenia. Psychiatr Clin North Am 2007;30:437-452.
12. Heres S, Hamann J, Kissling W, Leucht S. Attitudes of psychiatrists toward antipsychotic depot medication. Journal of Clinical Psychiatry 2006;67:1948.
13. Patel UB, Ni Q, Clayton C, et al. An attempt to improve antipsychotic medication adherence by feedback of medication possession ratio scores to prescribers. Popul Health Manag 2010;13:269-274.
14. Jaeger M, Rossler W. Enhancement of outpatient treatment adherence: patients' perceptions of coercion, fairness, and effectiveness. Psychiatry Res 2010;180:48-53.
15. Weiden PJ, Roma RS, Velligan DI, Alphs L, et al. The challenge of offering long-acting antipsychotic therapies: a preliminary disclosure analysis of psychiatric recommendations for injectable therapy to patients with schizophrenia. J Clin Psychiatry 2015:76:684-90.
16. Ehret MJ. Addressing unique medication adherence issues for patients with schizophrenia. Drug Topics 2016;54-62.
17. Phan SV, VandenBerg AM. Financial impact of a pharmacist-managed clinic for long-acting injectable antipsychotics. Am J Health Syst Pharm 2012;69:1014-1015.

APPENDIX A: STAKEHOLDER MEETING PARTICIPANTS

The individuals listed below were invited to participate in the project due to their background in pharmacy practice, caring for patients with chronic mental illness, or healthcare policy affecting pharmacists.

Of note, participants were only asked to represent their own opinions. Participants were not acting as representatives of their organizations but rather as individuals whose experiences with their various associations' memberships or stakeholders provide them with an informed perspective.

Name	Organization
George Bilyk*	Janssen
Antonio Ciaccia	Ohio Pharmacists Association
Michelle Cope	National Association of Chain Drug Stores
Christina DiMattia	Genoa, QoL Healthcare Company
Michelle Dirst	American Psychiatric Association
Jeff Doherty*	Janssen
Megan Ehret	Department of Defense
Anita Everett	Substance Abuse and Mental Health Service Administration
Darcy Gruttadoro	National Alliance on Mental Illness
Janet Haebler	American Nurses Association
CDR Ted Hall	United States Public Health Service
Ronna Hauser	National Community Pharmacists Association
Brian Hepburn	National Association of State Mental Health Program Directors
Lindsay Kunkle	American Pharmacists Association
Neil Leikach	Catonsville Pharmacy
Rob Leland	1st Avenue Pharmacy
Raymond Love	University of Maryland
Karen Ryle	National Association of Boards of Pharmacy
Sharonjit Sagoo	Substance Abuse and Mental Health Service Administration
Brenda Schimenti	College of Psychiatric and Neurologic Pharmacists
Beth Tschopp	National Council for Behavioral Health
Parisa Vatanka	American Pharmacists Association
Krystalyn Weaver	National Alliance of State Pharmacy Associations

*Observers

APPENDIX B: MEETING AGENDA

Identifying and Developing State Policy Best Practices for Pharmacist Administration of Medications

Agenda

Wednesday, December 14, 2016

Hotel Lorien
1600 King Street, Alexandria, VA
Meeting Room: Liberty B
http://www.lorienhotelandspa.com/hotels-in-old-town-alexandria/

8:00-9:00 a.m.	**Continental Breakfast**	Liberty B
9:00-9:15 a.m.	**Introductions and Overview** Raymond C. Love, PharmD, BCPP, FASHP Professor and Vice Chair Department of Pharmacy Practice and Science University of Maryland School of Pharmacy, Baltimore MD	Liberty B
9:15-10:00 a.m.	**The Need** Megan Ehret, PharmD, MS, BCPP Behavioral Health Clinical Pharmacy Specialist Department of Defense Fort Belvoir Community Hospital, Fort Belvoir, VA	Liberty B
10:00-10:45 a.m.	**Administration and Practice Models** Rob Leland, PharmD, BCPP Owner/Manager 1st Avenue Pharmacy Spokane, WA	Liberty B
10:45-11:00 a.m.	**Break**	Liberty B
11:00-11:30 a.m.	**The Policy Perspective** Antonio Ciaccia Director of Government & Public Affairs Ohio Pharmacists Association, Columbus, OH Krystal Weaver, PharmD, RPh Vice President, Policy and Operations National Alliance of State Pharmacy Associations, Richmond VA	Liberty B
11:30 a.m.-12:00 p.m.	**Policy and Best Practice Discussion** Setting the stage for our post-lunch discussion	Liberty B
12:00-12:45 p.m.	**Lunch**	Liberty A
12:45-3:30 p.m.	**Policy and Best Practice Discussion**	Liberty B

This work was coordinated by:

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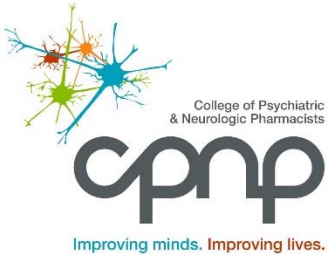

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